DENTI-CAL
CALIFORNIA MEDI-CAL DENTAL PROGRAM
P.O. BOX 15609
SACRAMENTO, CALIFORNIA 95852-0609
Phone 800-423-0507

DIRECT DEPOSIT ENROLLMENT FORM

1. New Enrollment ☐ Change Enrollment Information ☐ Discontinue Enrollment ☐

2. Provider Information:

   Provider Number: _____ Provider Service Office: _____

   Provider DBA Name: _____

   Provider's name as shown on bank account: _____

3. Banking Information:

   Please attach a VOIDED check from your bank account to this form in the space below:

TAPE YOUR VOIDED CHECK HERE

- Type of Account:

  ☐ Checking ☐ Savings

4. Discountinued Enrollment:

   Reason for Discontinued Enrollment: _____

5. Provider's Signature:

_____ _____
Provider's Signature (Requires Provider's Original Signature) Date

DO NOT WRITE BELOW THIS LINE

For Office Use Only

Date Entered: _____ Initials: _____

Instructions for Completing the Direct Deposit Enrollment Form

1. Check "New Enrollment," "Change Enrollment Information" or "Discontinue Enrollment".
2. Fill in your Denti-Cal Provider Number, Service Office Number, "Doing Business As" Name and the name shown on the bank account records.
3. Attach a VOIDED check to the form. Tape it to the blank space provided. Check the appropriate box for "Checking" or "Savings" to indicate the type of bank account.
4. For discontinued enrollment only: Fill in your reason(s) for discontinued enrollment.
5. Sign your name and fill in date. The **provider's original signature** is required. Rubber stamp signatures or initials cannot be accepted.
6. Send completed form to: **Denti-Cal/Enrollment Unit**
   California Medi-Cal Dental Program
   P.O. Box 15609
   Sacramento, CA 95852-0609